Health History – Medical Information
Student Health Care Center – Santa Fe College

OFFICE USE ONLY

Thank you for choosing the Student Health Care Center (SHCC) at Santa Fe College for your healthcare needs. Remember: We are here to help! The information you provide on this form is strictly confidential. The SHCC collects this information in order to provide comprehensive care.

MEDICAL HISTORY

MEDICATIONS: LIST PRESCRIPTIONS, OVER-THE-COUNTER MEDS, VITAMINS & SUPPLEMENTS.

MEDICATION NAME – OR WRITE "NONE":	DOSAGE & FREQUENCY:

DRUG ALLERGIES: LIST ALL PERTINENT INFORMATION.

DRUG NAME – OR WRITE "NONE":	REACTION:

PERSONAL HISTORY & REVIEW OF SYSTEMS

CONDITION: CHECK YES OR NO – CIRCLE CHOICE IF INCLUDED.	CURRENT YES	CURRENT NO	PAST (DATES ONLY)	CONDITION: CHECK YES OR NO – CIRCLE CHOICE IF INCLUDED.	CURRENT YES	CURRENT NO	PAST (DATES ONLY)
ALLERGIES*: ENVIRONMENTAL, FOOD, OTHER				HEART DISEASE			
ASTHMA				HEPATITIS			
BLOOD DISORDERS: ANEMIA, CLOTS, SICKLE CELL, OTHER				HIGH BLOOD PRESSURE/HYPERTENSION			
CANCER – LIST TYPE(S) HERE:				PSYCHOLOGICAL: ANXIETY, DEPRESSION, OTHER			
CHOLESTEROL/LIPID DISORDER				SEIZURES/EPILEPSY			
DIABETES: PRE-DIABETES, TYPE I, TYPE II				SKIN DISORDERS: ACNE, ECZEMA, RASH, WARTS, OTHER			
EAR, NOSE OR THROAT: HEARING, OTHER				SLEEP PROBLEMS: FATIGUE, INSOMNIA, OTHER			
EATING DISORDER(S): BINGING, PURGING, BODY IMAGE, OTHER				THYROID DISEASE			
EYE PROBLEMS: GLASSES, CATARACTS, OTHER				URINARY PROBLEMS: BLADDER INFECTIONS, UTI, OTHER			
GASTROINTESTINAL: CONSTIPATION, ULCERS, OTHER				WEIGHT GAIN/LOSS			
HEADACHES OR MIGRAINES							

***PLEASE ELABORATE ON ANY ANSWERS ABOVE:**

OTHER ISSUE(S) – LIST ALL RELATED INFORMATION:

ADDITIONAL INFORMATION: CHECK THE MOST APPROPRIATE BOXES.

IN THE PAST 2 WEEKS, HOW OFTEN HAVE YOU:

- FELT LITTLE INTEREST OR PLEASURE IN DOING THINGS: ☐ NOT AT ALL ☐ SEVERAL DAYS ☐ MORE THAN HALF THE DAYS ☐ NEARLY EVERY DAY
- FELT DOWN, DEPRESSED OR HOPELESS: ☐ NOT AT ALL ☐ SEVERAL DAYS ☐ MORE THAN HALF THE DAYS ☐ NEARLY EVERY DAY

HOSPITALIZATION(S) AND/OR SURGERY(IES): LIST SURGERY TYPE(S) AND DATE(S).

SOCIAL HISTORY

CONDITION: CHECK YES OR NO – CIRCLE CHOICE IF INCLUDED.	CURRENT YES	CURRENT NO	PAST (DATES ONLY)	CONDITION: CHECK YES OR NO – CIRCLE CHOICE IF INCLUDED.	CURRENT YES	CURRENT NO	PAST (DATES ONLY)
TOBACCO USE: CIGARETTES, DIP/CHEW, HOOKAH, OTHER				ALCOHOL USE			
ELECTRONIC CIGARETTE/VAPOR PEN USE				SUBSTANCE USE: MARIJUANA, PILLS, OTHER			

PLEASE ELABORATE ON ANY ANSWERS ABOVE:

MER-001_SFC: Reviewed 2017-03-02/ revised 2014-10-14

IMMEDIATE FAMILY HISTORY (MOTHER, FATHER OR SIBLINGS)

CONDITION: CHECK YES OR NO – CIRCLE CHOICE IF INCLUDED.	**YES**	**NO**	**FAMILY MEMBER**	**CONDITION:** CHECK YES OR NO – CIRCLE CHOICE IF INCLUDED.	**YES**	**NO**	**FAMILY MEMBER**
ALCOHOL OR SUBSTANCE ABUSE				DIABETES: PRE-DIABETES, TYPE I, TYPE II			
ASTHMA				HEPATITIS			
BLOOD DISORDERS: ANEMIA, CLOTS, SICKLE CELL, OTHER				PSYCHOLOGICAL: ANXIETY, DEPRESSION, OTHER			
CANCER – LIST TYPE(S) HERE:				THYROID DISEASE			
CARDIOVASCULAR: CHOLESTEROL, HEART DISEASE, HYPERTENSION				OTHER – LIST HERE:			
PLEASE ELABORATE ON ANY ANSWERS ABOVE:							

Health History – Sexual Health & GYN Information

Student Health Care Center – Santa Fe College

OFFICE USE ONLY

PLEASE NOTE: This page of the Health History is recommended but not required. Information provided here can help your healthcare provider make recommendations for additional health and wellness services; however, **if you do not wish to address any of the following health topics today, please draw an "X" over this page.**

SEXUAL HEALTH HISTORY

SEX ASSIGNED AT BIRTH: ☐ MALE ☐ FEMALE

GENDER IDENTITY: ☐ MALE ☐ FEMALE ☐ _____

SEXUALLY ACTIVE IN THE PAST 12 MONTHS: ☐ YES ☐ NO

IF NO: SEXUALLY ACTIVE IN THE PAST: ☐ NO ☐ YES

IF SEXUALLY ACTIVE, NOW OR IN THE PAST:

- MY PARTNER(S) HAVE INCLUDED: ☐ OPPOSITE SEX* ☐ SAME SEX* ☐ BOTH
  *SEX ASSIGNED AT BIRTH
- TOTAL NUMBER OF PARTNER(S), PAST 12 MONTHS: _____

CURRENT METHOD(S) OF SEXUAL TRANSMITTED INFECTION PREVENTION AND/OR BIRTH CONTROL:

_____

SATISFIED WITH METHOD(S): ☐ YES ☐ NO – SPECIFY: _____

CHECK YES OR NO – ELABORATE AS NEEDED.

- HPV VACCINE (GARDASIL OR CERVARIX): ☐ NO ☐ YES ☐ NOT SURE
- HISTORY OF SEXUAL TRANSMITTED INFECTION: ☐ NO ☐ YES – SPECIFY: _____
- SEXUAL CONCERNS: ☐ NO ☐ YES – SPECIFY: _____
- PAINFUL INTERCOURSE: ☐ NO ☐ YES– SPECIFY: _____

HISTORY OF EMOTIONAL, PHYSICAL OR SEXUAL ABUSE AND/OR SEXUAL ASSAULT: ☐ NO ☐ YES – COMMENTS OPTIONAL:

_____

_____

IF APPLICABLE – GYNECOLOGICAL HEALTH HISTORY

OBTAIN REGULAR GYNECOLOGICAL CARE

☐ YES ☐ NO

LAST PELVIC EXAM (MM/DD/YYYY)

___ ___ / ___ ___ / ___ ___ ___ ___

LAST PAP SMEAR (MM/DD/YYYY)

___ ___ / ___ ___ / ___ ___ ___ ___

HISTORY OF ABNORMAL PAP

☐ YES ☐ NO

IF YES TO ABNORMAL PAP: DATE (MM/DD/YYYY)

___ ___ / ___ ___ / ___ ___ ___ ___

IF YES TO ABNORMAL PAP: SPECIFY FOLLOW-UP.

CHECK YES OR NO – ELABORATE AS NEEDED.

- FREQUENT BLADDER INFECTIONS: ☐ NO ☐ YES – SPECIFY: _____
- FREQUENT VAGINAL INFECTIONS: ☐ NO ☐ YES – SPECIFY: _____
- OVARIAN CYST(S): ☐ NO ☐ YES – SPECIFY: _____
- BREAST PROBLEMS OR SURGERY: ☐ NO ☐ YES – SPECIFY: _____
- GYNECOLOGICAL SURGERY: ☐ NO ☐ YES – SPECIFY: _____

IF APPLICABLE - MAMMOGRAM AND/OR ULTRASOUND: INDICATE DATE(S) AND FINDINGS. _____

IF APPLICABLE – MENSTRUAL HISTORY

FIRST DAY OF LAST MENSTRUAL PERIOD (MM/DD/YYYY)

___ ___ / ___ ___ / ___ ___ ___ ___

WAS IT NORMAL FOR YOU?

☐ YES ☐ NO

_____

AGE (IN YEARS) AT FIRST MENSTRUAL PERIOD

PROBLEMS WITH PERIOD NOW (EX: BAD CRAMPING, PMS, ETC.)

☐ NO ☐ YES– SPECIFY:

_____

PROBLEMS WITH PERIOD IN THE PAST

☐ NO ☐ YES

_____

HOW OFTEN DO YOU GET YOUR PERIOD?

LENGTH OF YOUR PERIOD	FLOW (CIRCLE ONE): LIGHT MEDIUM HEAVY VERY HEAVY OTHER – DESCRIBE:_____

IF APPLICABLE – PREGNANCY & BIRTH (OBSTETRICAL) HISTORY

PREGNANCY(IES): PLEASE INDICATE THE FOLLOWING: ___# LIVING CHILDREN ___# FULL-TERM BIRTHS ___# PRE-TERM BIRTHS ___# SPONTANEOUS MISCARRIAGE / ELECTIVE ABORTION

Health History – General Information
Student Health Care Center – Santa Fe College

OFFICE USE ONLY

PATIENT/STUDENT INFORMATION

PATIENT/STUDENT NAME (LAST, FIRST, MIDDLE INITIAL)		OTHER NAMES/ALIASES, PREFERRED PRONOUNS		**SFC ID NUMBER**
LOCAL STREET ADDRESS		CITY, STATE	ZIP CODE	CELL PHONE, INCLUDING AREA CODE
PERMANENT STREET ADDRESS – IF APPLICABLE		CITY, STATE	ZIP CODE	OTHER PHONE, INCLUDING AREA CODE
BIRTH DATE (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___	SEX ASSIGNED AT BIRTH ☐ MALE ☐ FEMALE	GENDER IDENTITY ☐ MALE ☐ FEMALE ☐ _____		PRIMARY LANGUAGE – *TRANSLATOR NEEDED?* ☐ NO ☐ YES

MARITAL STATUS: ☐ SINGLE ☐ SIGNIFICANT OTHER ☐ LIFE PARTNER ☐ MARRIED ☐ LEGALLY SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ OTHER ☐ UNKNOWN

ETHNICITY: ☐ HISPANIC/LATINO(A) ☐ NOT HISPANIC/LATINO(A) ☐ UNKNOWN ☐ DECLINE

RACE: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ WHITE ☐ OTHER ☐ UNKNOWN ☐ DECLINE

EMERGENCY CONTACT

NAME	OTHER NAMES/ALIASES, PREFERRED PRONOUNS		**RELATIONSHIP**
STREET ADDRESS	CITY, STATE	ZIP CODE	**CELL PHONE, INCLUDING AREA CODE**

OTHER HEALTHCARE PROVIDER YOU SEE ON A REGULAR BASIS (PRIMARY CARE PROVIDER)

NAME	**TYPE OF HEALTHCARE PROVIDER**		**BUSINESS PHONE, INCLUDING AREA CODE**
STREET ADDRESS	CITY, STATE	ZIP CODE	DATE(S) OF CARE

PERMISSION FOR DIAGNOSIS & TREATMENT PROCEDURES

I hereby authorize the healthcare providers of the University of Florida (UF) Student Health Care Center (SHCC) at Santa Fe College (SFC), their agents or consultants, to perform diagnostic and treatment procedures that, in their judgment, may become necessary while at SFC. I understand that I am responsible for further charges incurred and authorize the University Faculty Group Practice and SHCC to release medical information necessary to process medical claims. I authorize release of any information to county, state or federal public health agencies, as required by law. **Parental consent for diagnosis and treatment is required for patients under the age of 18.**

NOTE: If you would like to communicate with a third party about your current condition(s), please give your healthcare provider contact information and verbal permission.

PATIENT NAME - PRINTED	**PATIENT SIGNATURE**	**DATE**
FOR OFFICE USE ONLY: PROVIDER NAME - PRINTED	*PROVIDER SIGNATURE*	*DATE*